

and if two visitors are admitted at one time there may be considerable conversation between each and a certain amount of rivalry in attracting the interest of the invalid, and the visits become anything but restful.

The object of visiting is to soothe and encourage the invalid and aid his recovery. It is not to interest or amuse the visitor. Accordingly, bad news should be kept away from the sick-bed as far as may be, but all direct questions should be answered accurately and great care taken to prevent any suspicion that anything is being kept back. The visitor should do most of the talking and report interesting occurrences in the home or among intimate friends of the patient. Even listening to conversation of this sort may be tiring, and the visitor should be prepared to sit quietly without speaking for intervals of some minutes. The custom of bringing fruit or flowers by a visitor to a patient in hospital, though sound in principle, may easily become an imposition. It is encouraged by traders who operate on visiting-days just outside the entrance to a hospital or even within it. But patients welcome visitors for what they are and not for what they bring. No one should be deterred from visiting, therefore, because they have no gift to offer; indeed, too many offerings may be an embarrassment, if not to the patient at least to the hospital staff. Might it not be useful to provide a list of suggestions to visitors, either on the visiting-card or in the form of a notice outside the ward?

Information for Visitors.—It is not always desirable that patients should be told the exact nature of their trouble. Moreover, this may be difficult to explain in a few words, and an insufficient explanation may give rise to much anxiety and suspicion of serious disease that does not really exist. Nevertheless, some responsible relation who can be trusted for discretion ought to know the truth, put in as favourable a light as possible. This is especially important when husband, wife, or child is the occupant of a hospital bed. But to whom is the responsible relation to turn? The sister may not know every detail, and in any case it is not her duty to be catechized on the nature of her patient's trouble. The house-physician or house-surgeon is generally a junior officer who may or may not be fully qualified and who has had no great experience in dealing with people. The consultant-in-charge is a busy man and not likely to be available during visiting-hours. Would it not be useful if the registrar, who is second in command to the consultant and is a person of experience, should be available during a visiting-time once a week, preferably an evening, to answer the very real problems that present themselves to near relatives?

No Visitors.—The prestige importance of visitors must not be forgotten. This is no great matter in acute or short-stay wards, in which it is easy for the patient to explain that his or her relatives and friends are very busy or live a long way off. But in chronic sick wards many of the people are elderly, read but little, and talk to each other mainly about their illnesses or children and grandchildren. I recall that during the war I had occasion to visit old people evacuated from London in a dozen cities of the Midlands. Almost without exception they said that they cared nothing for the bombs but begged to be allowed to return to London to be near their children and grandchildren. The chronic sick feel that if they but rarely have visitors their colleagues in the ward will think there is something lacking in them personally. It is therefore a real act of mercy for well-disposed people to visit them regularly.

Special Report

SYMPOSIUM ON OBESITY

A Symposium on Obesity, organized by William R. Warner & Co. Ltd., was held at the Royal College of Surgeons on Friday, March 29. Professor A. KEKWICK (London), Professor G. BROWNLEE (London), and Professor D. HUBBLE (Birmingham) took the chair for the three sessions. Papers were presented on metabolic abnormalities in obesity, on drugs used in its treatment, and on problems in therapy and prognosis of obesity.

Metabolism and Obesity

Dr. G. C. KENNEDY (Cambridge) stressed the importance of decreased activity as a factor in the production of experimental hypothalamic obesity in rats. A normal rat ran about 20 kilometres a day on a treadmill, but after destruction of the ventromedial nuclei of the hypothalamus activity decreased almost to zero and the animal's weight simultaneously increased. Appetite-suppressing drugs did not stimulate activity in these rats. Occasional disturbances of gonad function were also seen after these hypothalamic lesions, but occurred, too, when the lesions were more anterior. It was probable that the hypothalamus of the rat consisted of overlapping bands rather than discrete functional centres, an antero-posterior band concerned with gonad function and a medio-lateral band affecting appetite and activity.

Dr. M. M. WINBURY (Warner-Lambert Research Institute, New Jersey) described studies on cats with electrodes implanted in the hypothalamus. Electrical stimulation of the lateral nuclei made the cats eat food, even though satiated, and increased their activity. An anorectic drug, chlorphentermine, prevented the feeding response to stimulation, but not the activity. The electrical potentials in the lateral and ventromedial hypothalamic nuclei evoked by stimulation of different areas of the brain were recorded with the use of a computer, and the effect of chlorphentermine studied. In a fasting cat chlorphentermine produced potentials in these nuclei which resemble those associated with a state of satiety, and also modified the effect of hypoglycaemia on the potentials.

Metabolic Abnormalities

Mr. C. L. S. PAWAN (London) reviewed the metabolic abnormalities which may be associated with obesity in man. Obesity was not always simply a quantitative response to calories eaten, since some fat individuals ate less than thin ones. Obesity might indicate a state of "functional under-nutrition" of the cells of the body, to which the organism responded by a decreased expenditure of energy. At the Middlesex Hospital Mr. Pawan and his colleagues had demonstrated a "fat-mobilizing substance" (FMS) present in urine from individuals of normal weight and also from obese patients on a diet providing 90% calories as fat, but absent in such patients when they received a diet with 90% calories as carbohydrates. In mice administration of FMS led to increased excretion of carbon compounds in the urine, but not of expired CO₂; it thus differed in its metabolic effects from thyroxine. Obese patients were abnormally resistant to ketosis, negative nitrogen balance, and the fall in blood sugar and bicarbonate which normally occurred with starvation. ¹⁴C-labelled glucose, palmitate, acetate, and β -hydroxy-butyrate were all metabolized more slowly than normal in obese individuals.

Dr. I. MCLEAN BAIRD (Barnsley) showed that "simple" obesity and Cushing's syndrome sometimes had several features in common, and could be easily confused. Obese patients might have purple striae, amenorrhoea, hypertension, and decreased carbohydrate tolerance. In 20 obese women the urinary excretion of 17-ketogenic steroids had been significantly higher than that of a control group, and

some of these high levels did not appear to be suppressed completely by 9 α -fluorohydrocortisone. Dietary restriction in six obese patients was followed by a fall in 17-ketogenic steroid excretion to normal levels. These results suggested that adrenal cortical overactivity might occur in some patients as a result of obesity.

Drugs for Obesity

Professor W. H. TRETOWAN (Birmingham) spoke of the dangers of addiction to anorectic drugs of the amphetamine group, and the psychotic reactions which they might produce. Addiction to these compounds was commonly associated with alcoholism or addiction to other drugs in the same patient. Tolerance could occur rapidly and patients might take up to 1,500 mg. amphetamine daily. Severe moral deterioration might ensue, but withdrawal symptoms were generally less severe with the amphetamine-like drugs than in the case of narcotics or alcohol. The psychotic reactions resembled paranoid schizophrenia, and usually subsided within 10 days of stopping the drug. Obese individuals might be especially liable to addiction, in fact some of them might be already addicted to food, while others over-ate to relieve depression. The amphetamine-like drugs were probably prescribed too freely.

Dr. I. MØLLER-NIELSEN (Copenhagen) reviewed the pharmacology of the sympathomimetic amines. These drugs depressed appetite through a central effect, but in addition they increased mobilization of fat from the fat stores of the body, and this might also contribute to their weight-reducing action. Some drugs had a greater effect on the cardiovascular system, others acted mainly on the central nervous system. Chlorphentermine, which had a chlorine atom in the *para* position, was not metabolized in the same way as the other amines, and had a more prolonged anorectic action. In addition, it produced sedation rather than stimulation in man, and did not increase activity in animals. It had less effect on the cardiovascular system than amphetamine.

Controlled Trials

Dr. P. M. F. BISHOP (London) described double-blind trials carried out with phenmetrazine ("preludin") and chlorphentermine ("lucofen"). Obese patients were given either the drug or a placebo together with a 1,000-calorie diet for a four-week period, and then received placebo or drug alternately for two further four-week periods. When the active drug was given first, significantly more weight was lost in that period than when the placebo was given. In the subsequent periods, however, the superiority of the drug over placebo became less and could not be demonstrated at all in the third period. Patients varied a great deal in their response. Dr. Bishop believed that the only way to reduce weight was to eat less. About 80% of patients failed to keep to their diets, usually within a year. Patients with post-partum obesity and those over 20 stone (127 kg.) were particularly difficult to treat.

Dr. J. A. WEAVER and Dr. C. LUCEY (Belfast) presented similar studies with anorectic drugs, and showed the decreasing usefulness of the drugs in succeeding months. These drugs ought only to be used for short periods in the treatment of obesity. Constant supervision of the patients was necessary to achieve any lasting reduction of weight.

Prognosis

Dr. O. H. WOLFF (Birmingham) reported long-term prospective studies of obese children. After an initial response to dietary restriction a relapse usually occurred, and only about a quarter of the children were less than 20% overweight 10 years later. The children who were initially most overweight were still the fattest ones after nine years. An initial good response to treatment did not indicate that this would be maintained. Dr. Wolff suggested that better results might be obtained in treating obese children if activity were encouraged, with physiotherapy, and diet not overstressed; if psychological upsets could be dealt with; and if the patients were followed up for a prolonged period.

Dr. I. D. MACDONALD (London) reviewed recent actuarial studies on obesity. Individuals more than 40% overweight

had an actual expected mortality ratio of 187%, but those who had reduced successfully had a normal mortality ratio. Coronary heart disease and cerebrovascular accidents were significantly more frequent causes of death in obese individuals. It was estimated that 6% of men and 11% of women were more than 20% overweight.

In concluding the symposium Professor KEKWICK spoke of the many advances in knowledge of obesity that had taken place in the last 20 years. Many complex factors were now known to be involved, and students of obesity could no longer regard the condition as simply the result of gluttony.

FORENSIC MEDICINE CONFERENCE

The Third International Meeting in Forensic Immunology, Medicine, Pathology, and Toxicology opened at the School of Pharmacy, London University, on Tuesday, April 16. The first item was the installation as President of Professor FRANCIS CAMPS (London) in succession to Dr. MILTON HELPERN (New York). The meeting then proceeded with a plenary session devoted to the "Organization of the Investigation of Sudden and Unnatural Deaths." Dr. HELPERN presided at the session. He said that in recent years there had been a tendency to put a great deal of emphasis on the necropsy and to forget the importance of investigation; he was pleased to see in the title of the session the words "Organization of the Investigation."

The opening speaker, Professor HARALD GORMSEN (Copenhagen), said that the subject was of fundamental importance to the administration of justice and to the question of compensation. Hence it had an important bearing on the social security of every citizen in the widest sense of the word. The investigation should not be concerned solely with the clearing-up of suspicion. It should also embody the classification of any unexplained, unexpected, and unnatural deaths. This would greatly assist in the assessment of certain factors such as the effect of insecticides on plants and foods. The system should therefore have both a judicial and a social aspect.

Coroners' System

Dr. GAVIN THURSTON (London), presenting his paper on the English coroners' system, said that the characteristic of the system was publicity, and the advantages of this were obvious. First, rumour was dispelled. Secondly, it would be an affectation to pretend that the inquest findings did not have the most extreme value in the ultimate decision of a civil case.

In larger coronerships, and certainly in London, post-mortem examinations were always carried out by specialists. There were a few areas where general practitioners still carried them out, but he would not like the meeting to think that this was a regular thing or something of which the Coroners' Society of England and Wales approved. The number of coroners using general practitioners for this work was only about 3% and gradually the practice was being given up.

Dr. Thurston said arrangements for post-mortem examinations were fairly good but not perfect; however, we were lagging behind in toxicology for two reasons. First, there was extreme understaffing at the Home Office Forensic Science Laboratory, and, secondly, so much time was wasted by the laboratory staff in having to attend in person to give evidence in court.

He suggested an arrangement similar to that in the Pharmacy and Medicine Act, 1941, whereby a written report by the Director of the Laboratory would be admissible with the right to call the analyst in person if objection was taken. The prime need at the moment was for far more toxicology facilities in England and Wales.